# *Analysis of a nursing survey: Reasons for compromised quality of care in inpatient mental health wards.*


## *Abstract*

Current evidence suggests understaffing is related to poor quality and missed care in a global context, but this relationship is complex. There is also a research gap for quality in mental health care in the United Kingdom that includes a wider set of patient outcomes. This paper aims to investigate RMN's perception of quality of care on their last shift, their self-reported reasons for compromised care and potential impact on patient outcomes. A mixed methods approach, we used descriptive statistics to create a framework within which to qualitatively analyse data from the 2017 Royal College of Nurses (RCN) employment survey to consider the complex relationship between understaffing and care quality. We established three themes: 'Understaffing', 'Professional Code Expectations and Moral Distress' and 'Management'. Consistent with the current evidence; lack of resources and understaffing were consistently present throughout. Nurses also felt pressure from the Nursing and Midwifery Council (NMC) code of conduct which in turn instilled shame and fear for their registration when they were unable to achieve the standards expected. This was further exacerbated by poor management and supervision; leading nurses to reflect on poor outcomes for patients which compromised not only legal rights but safety of patients and staff alike. We conclude that focusing on staffing numbers alone is unlikely to improve care quality.

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Keywords

Mental Health, Quality of Health Care, Workforce, Employment

## *Introduction*

There is evidence that understaffing leads to poor quality and missed care. Understaffing is a chronic problem in health care, exacerbated by cuts in public funding and austerity (Cummings, 2018). Given nursing staff drive the primary therapeutic interventions in care (Baker et al 2019); using data from the 2017 Royal College of Nursing (RCN) employment survey, this paper considers the relationship between staffing resources and care quality in the last five years.

## *Background*

The United Kingdom (UK) National Health Service (NHS) has experienced increased pressure under national welfare reform which has been central to UK government policy since 2010 (Department of Health 2010), welcoming cost saving service 'reconfigurations' in the context of a limited evidence base (Imison et al 2014). This has placed an unprecedented strain on mental health services both before (UNISON 2017a; 2017b) and during, the coronavirus pandemic (British Medical Association 2020). In 2017, the NHS publicly acknowledged nurse shortages across healthcare, in the UK's 'Stepping Forward to 2020/21' mental health workforce plan (Health Education England 2017). Around this time a host of policy documents, guidelines and frameworks on safe staffing and quality improvement were published (Care Quality Commission 2015; National Institute for Health Care Excellence 2014; Kilbourne 2018; Ross and Naylor 2017; Royal College of Nursing 2017; UNISON 2017). The Care Quality Commission expressed concerns in a 'state of care' report for mental health services specifically (Care Quality Commission 2017) and more recently (Care Quality Commission 2020) argued the lack of improvement in quality of care was exacerbated by the pandemic; especially for those detained under the Mental Health Act whose essential hospital leave was cancelled and tight restrictions on movement introduced (British Medical Association 2020).

While reduced staffing relates to poorer outcomes, the following studies (first in general adult nursing, then mental healthcare) paint a complex picture. In the United States (US), Kalisch et al (2011) and Kalisch and Xie (2014) highlighted poor staffing resources that led to missed care, impacting on patient outcomes in general hospitals;

findings which were also found in a UK sample (Ball et al 2014). In South Korea, Cho et al (2019) found poorer staffing to be associated with an increased number of missed care activities, which in turn were associated with poorer patient safety, quality of nursing care and a higher intent to leave employment. In a systematic review of nurse/patient ratios in the US, Lang et al (2004) found nursing hours and skill mix affected some important patient outcomes such as inpatient mortality and hospital stay length. In contrast, a later international review by Shin et al (2018) found *higher* nurse to patient ratios to have a negative impact on nurse outcomes, specifically burnout and intent to leave.

Evidence from mental health care environments suggests further complexity. In the UK, Bowers et al (2007) found increased adverse incidents during weeks of high regular staff absences and male admissions. However, later findings from Bowers et al (2009) and Bowers and Crowder (2012) suggest an increase in patient aggression and adverse events with higher staffing numbers. Chou et al (2002) also found higher staffing numbers related to increased incidents of aggression in acute mental health wards in Taiwan. In the US, Staggs (2013; 2015) found reported assaults went up with increased numbers of qualified nurses on shift. While these findings may conflict with intuitive understandings that increased staffing leads to better quality of care, they do highlight the complexity of mental health inpatient care on an international level. Nurse competence and educational levels often vary widely, which impacts on care quality and patient outcomes as outlined by authors from Canada and the US (Frechette et al 2018; McNelis and Horton-Deuch 2012). Compared to general adult nursing, mental health nursing is also more characterised by human relationships and interpersonal phenomena which may impact on violence and aggression. In interviews investigating the views of inpatient and community mental health staff in the UK, respondents felt safe staffing was more complex than just having ‘enough’ staff and outlined multiple reasons why chronic understaffing impacts safety and quality of care (Baker et al 2019) such as morale and the attrition of experienced staff.

In the context of the evidence presented, an understanding of environmental culture, skill mix and wider set of service user outcomes (such as safety and recovery) is missing**.** Using a mixed methods design, this paper aims to investigate mental health nurses’ perception of quality of care on their last shift, their self-reported reasons for

compromised care and the impact on patient outcomes. This paper aims to contribute to our knowledge of staffing and care quality and presents ideas for future research.

## *Methods*

This is a secondary analysis of a cross-sectional study of Registered Mental Health Nurses (RMN's) from mental health inpatient services in the UK. The survey was developed and administered in May 2017 by the Royal College of Nursing (RCN), the UK's largest professional nursing body. Before work commenced, a data sharing agreement was obtained between The University of Sheffield and the RCN. All data was anonymised prior to being shared with the research team. Ethical approval was obtained on 27/08/2019 (Reference Number 026774) to conduct a secondary analysis of the anonymised RCN survey.

We employed a mixed methods study design in a hybrid approach (Fereday and Muir-Cochrane 2006) involving deductive and inductive thematic analysis (Braune and Clark 2006). The survey questioned whether care was compromised and possible reasons, and these questions comprised the initial framework to organise and explore the qualitative data. In the first stage, the quantitative survey data was descriptively analysed (Table 1 and 2) and used as a 'framework' to structure a thematic analysis in a deductive approach. In the second stage, inductive reasoning was used to thematically analyse the open text responses from the survey.

## *Measured Outcomes*

In the survey, all responses related to nurse's experience of their most recent shift. Percentages represent the responses of nurses' perceived self-reported quality of care delivered, whether they felt it was compromised (Table 1) and the factors that affected quality of care (Table 2). The survey questions were phrased as: *"Do you feel patient care was compromised during your last shift/ day at work*?". Respondents could choose between the options '*Yes', 'No'* and '*Don't Know'* (Table 1). Respondents were then asked "*What do you think had the most significant impact on your/ the team's ability to deliver high quality care? Select all that apply*" on a number of other factors that could impact on care quality (see Table 2). In addition to these, an open text question was included – "*Please share examples about the impact that staffing levels have had on you and those you care for, we are keen to hear both positive and*

*negative stories"*. There was no word limit set on the length of replies and these were analysed qualitatively.

### *Data Analysis*

The 'non-response' categories of 'Neither good/or poor' (Question 1) and 'don't know' (Question 2) were recoded into category "Chose not to Say" which was not treated as missing data and included in the analysis. Tables 1 and 2 present the framework: a set of priori or empirical 'codes' which helped to contextualise the open text responses and structure our qualitative analysis. The researchers (ET, MS) applied, then reapplied this framework to the qualitative data in a deductive, cyclical manner using QuirkosTM software. Two researchers then, (ET, MS) using an inductive, interpretative approach, constructed further codes from the open text response data and grouped these into 'subthemes' and overarching 'themes' (Figure 1).

The process of analysis aligned most closely with that of 'abductive reasoning'; where research is not exclusively driven by theory or data and forms a process of uncovering meaning which is not wholly inductive or deductive (Raholm 2010). A constructivist-interpretive approach was used when analysing the open text responses thematically (Levitt et al 2017) and methodological integrity was promoted by the researcher (Author 1) having worked for years in various mental healthcare settings, to ensure the analysis remained contextualised. Themes and subthemes held the structure while surface and latent structures were uncovered and integrated. This was an iterative and dialectical process whereby the research team (ET, MS, TS) aligned the quantitative framework with the qualitative outcomes whilst considering pre-existing knowledge and research and integrating these empirical understandings into the analysis.

## *Results*

### *Quantitative Findings*

There were 1126 survey responses counted from inpatient RMNs. The 'Understaffing' variable was calculated as a measure of the planned number of RMNs from the shift. The measured outcome frequencies for 'Yes', 'No' and 'Choose not to say' are reported with frequency and proportion percentages in Table 1 and 2.

Around one-third (n=388, 34%) of nurses reported understaffing on their last shift. Just under half (n=199, 47%) of nurses felt care was compromised on their last shift; 42% (n=176) felt it was *not* compromised, 11% (n=45) chose not to say. Lack of nurses (n=346, 30.7%), higher patient acuity (n=331, 29.4%) and too much time spent on non-nursing duties (n=306, 27.2%) were reported quantitatively as the top three determinants of compromised care.

### *Qualitative findings*

Responses to the open question varied considerably in length and the amount of detail provided from just a couple of sentences to one/two paragraphs. Due to the large amount of data, data saturation was agreed at 40%, which occurred when we reached the 530$^{th}$ response. As guidelines by Braun and Clarke (2006) recommend at least 100 respondents for analysis of open text responses, we felt data saturation was achieved.

Respondents were RMNs, ranging from preceptorship level staff nurse to senior management. We constructed three main themes; 'Understaffing', 'Professional code expectations and Moral Distress' and 'Management' with a number of subthemes (Figure 1). 'Patient outcomes' were conceptualised as consequences for the patients experience.

### *Understaffing*

Respondents directly cited limited staffing as reasons for compromised care, and while this impacted on almost every aspect of care on the ward, consequences manifested in other ways, most notably 'overwork':

*"Being the only staff nurse on ward is a huge responsibility for such complex unwell patients, having to do all nursing jobs on top of assisting others to due lack of staff and missing breaks, staying late in work to catch up on paperwork to name but a few issues, leaving staff morale very low on ward as everyone is always exhausted and over worked".*

Compromised safety of both patients and staff were frequently identified. Respondents described injury and missed essential care. Self-harm was identified as a specific

issue when one to one care was not possible, along with de-escalation of violence and aggression:

*"Staff and patients have been injured on my ward, due to inappropriate staffing levels. Staff are unable to do personal care and spend the 1:1 time needed to support and de-escalate patients. As a result, agitated patients escalate, and can have aggressive outbursts".*

Nurses who work hard to keep their patients safe on the ward are acutely aware of their responsibility under medication administration, including not only the risk of harm they could cause to a patient in their care, but errors that would jeopardise their professional registration. Administering for up to 25 patients requires high levels of concentration to avoid error:

"*Because I was alone during night shift it is at times a big challenge to administering medication without a near miss or error, which if we are two staffs would [be] safer and less challenging".*

These immediate issues of safety culminate in higher than expected work-related strain.

### *Professional Code Expectations and 'Moral Distress'*

In the context of the high expectations set out in the Nursing and Midwifery Council (NMC) code of conduct; a high proportion of respondents spoke passionately about the care they wanted to provide, and their patients should rightly expect. The pressure to achieve the very high standards of care expected was often, however, associated with a personal cost to the nurse. The prioritization of the health of the patient was articulated as a strategy by many of those who took part in the survey, occurring as a result of missing breaks and working unpaid overtime. When care standards fell below what was expected, respondents reported guilt, shame and anger, synonymous with 'moral distress':

*"When I leave the ward with ladies in the same clothes they have been in for days because I or the other staff haven't had the time to spend with them I feel ashamed to be a nurse"*

High standards demanded as part of their professional registration, influence nurses' own thought processes when making sense of their positions. These data indicate that for many respondents' work-related exhaustion had impacted on their own health, private lives and that of their families, as they tried to provide the best possible care required, no matter what:

*"I am a single mother of a 12 year old boy, he has recently transitioned to secondary school. I cannot remember the last time I finished a shift on time, Nor can I remember the last time I finished and had the energy to give my son the positive attention he deserves….. I feel exhausted when I get home. As I write this, I feel overwhelmed with sadness…."*

There is a clear sense of resentment in these data. Nurses don't feel prioritised or cared for in an emotionally demanding job where they feel, due to the demands of the code they work under, they are not able to meet their own basic needs let alone provide good quality care.

### *Management*

While some respondents reported having supportive managers, others described a sense of frustration, resentment and mistrust. Descriptions ranged from poor responses to concerns, a lack of supportive supervision and a culture of blame and bullying. Respondents felt the pressure of high standards from senior staff without the support needed to achieve this; resulting in feelings of shame, guilt, and poor care quality:

*"Staff who feel guilty for providing sub-standard care and making mistakes from exhaustion may also hear this from their management in a climate of blame and finger-pointing"*

Staff felt unable to raise concerns about staffing, and those that did described a culture of dismissal or inaction. The effect of this management style appeared to heavily impact morale; respondents described facing incredible levels of risk, with little sense of protection or support from the organisation:

*"We get berated if we submit Datix forms about dangerous staffing levels and we often work with no managers on shift and just one qualified nurse. We also are expected to*

*do the duties that would be expected of a ward clerk and are constantly criticised by management as they feel we are lazy and not performing. It's a terrible situation".*

Overall, when there is a lack of staff, high standards of care imposed by codes of conduct and management (who provide at best, poor support or at worst, promote a culture of blame), care quality is compromised through minimised and missed care, absenteeism, self-sacrifice and a sense of poor morale, burnout, guilt and shame.

### *Outcomes for Patients*

Respondents described the consequences of poor management of patient aggression and distress for patient safety. This respondent describes cycles of serious self-harm and incidents of assault from other patients:

*"Poor staffing levels where I work often leads to my patients having poor outcomes, either through not having up to date care plans or paperwork, but also that they engage in challenging behaviour including serious ligatures and assaultive behaviour, which in turn creates a vicious cycle."*

Nurses frequently pointed to being unable to provide one to one care, despite this being essential not only to avoid incidents but to progress in patient recovery and work towards discharge:

*"My ability to deliver safe effective care is compromised and this impacts on the patient's mental well-being as there is not enough time to spend with the patients to aid their recovery"*

One of the most concerning (and frequently cited) aspects of patient outcomes and missed care was the omission of escorted leave. Under Section 17 of the Mental Health Act; people who are detained are legally entitled to leave from the ward; in fact, this is a vital aspect of recovery and discharge:

*"Sometimes patients detained under the Mental Health Act are denied escorted S17 leave because there are no staff available to escort them. This means they are missing out on a vital part of their recovery/rehabilitation."*

Not only is leave vital for recovery and the phased reintroduction into public life, it is also a legal and human right. Patients sectioned under the Mental Health Act are protected by the safeguards it provides; if these are not implemented (agreed leave

being denied on the basis of resources) health trusts are potentially unlawfully depriving liberty.

### *Summary of Findings*

*Almost half of nurses* reported compromised care on their last shift (n=199, 47 %), whilst 45, (n=11%) chose not to respond to this question at all. Out of the respondents that answered: '*Understaffing'*, '*Higher Patient Acuity'* and 'T*oo Much Time Spent on Non-Nursing Duties'* were reported as '*reasons for compromised care'*. Open text responses described the consequences of understaffing; underpinned by lack of resources. While 'understaffing' was heavily cited, the identification of other issues helped highlight complex difficulties nurses face on a day-to-day basis which impact directly on outcomes for patients. When nurses were unable to achieve the standards expected, often due to poor management and lack of supervision, they reflected on the poor outcomes for patients, especially safety and recovery.

## *Discussion*

Results from this paper describe a compromise in quality of care in acute mental health hospitals by RMN's, the interrelating reasons, and resultant patient outcomes. Prior to this study, the Care Quality Commission in 2015 outlined concerns indicating poor staffing issues such as staff burnout, lack of 1:1 time with patients, high use of agency staff and cancelled patient leave in mental health settings in the UK; (Care Quality Commission 2015) all consistent with the themes in our data. In the time since the survey was administered, the world has experienced the ravages of the Covid-19 pandemic and prolonged lockdown, which have exacerbated the situation for mental well-being in society and particularly for the already disadvantaged (Care Quality Commission 2020). In our data, nurses attribute sub-optimal staffing to poor nurse and patient outcomes, however we considered the complexity of this. Existing data from both UK and USA general and mental health care environments suggest contradictions in the relationship between staffing resources and patient outcomes (Bowers, 2007; Bowers et al, 2009; Bowers and Crowder, 2012; Staggs, 2013; Staggs, 2015; Staggs, 2019).

Our theme of 'Professional Code Expectations and 'Moral Distress', focuses on the feelings invoked in response to the professional standards of care demanded of

nurses, such as the NMC code of conduct here in the UK. There is compelling evidence that moral distress is a feature of mental health nursing that is positively correlated with work related strain, burnout and poor professional efficacy (Lamiani, Borghi and Argentero, 2017). When nurses repeatedly fail to 'live up' to the standards, a 'crescendo effect' occurs (Epstein et al 2019) exacerbated by the system level causes such as understaffing. Our data is a visceral demonstration of nurses devastation, not only at their failure to live up to professional standards but a loss of pride in being unable to deliver good quality care. Feelings of pressure lead to shame and fear for their NMC registration because they were unable to achieve the standards expected and they are faced with providing substandard, unsafe care, that in the case of Section 17 leave, could even be unlawful.

Poor skill mix and competency levels further impact problems caused by poor staffing. With any inpatient environment competencies vary; new nurses still in training require support. Qualified staff are responsible for vital care such as medication management, where two staff are required to safely administer. Safe management of violent or aggressive patients also requires a good mix of experienced staff. Baker and Pryjmachuk (2016) argue nurses' professional status and specialist skills are of paramount importance to safety overall; numbers are not enough. This lack of skill mix may explain unexpected counterintuitive findings (Bowers 2007; Staggs, 2013; Staggs, 2015; Staggs, 2019) such as more increased adverse events with higher staffing levels.

The 'Management' theme further highlights the complexity of mental health care environments. Our findings suggest managerial practice adversely impacted care quality as detailed in comments on nurses' experience of stress and work dissatisfaction. Stone et al (2011) found organisational and managerial practices were stronger predictors of suspension than the characteristics of individual nurses. They argue when 'poor performance' is responded to in terms of individual culpability, nurses risk becoming the focus for chronic systemic problems. These findings also link to issues of 'lateral violence' as summarised by Roberts et al (2015); in the absence of supportive and consistent leadership, learned behaviours such as bullying and hostility flourish in the face of unequal workplace power dynamics. When nurses feel demonised and under scrutiny, their ability to provide good quality care is

compromised and their own wellbeing and mental health is jeopardised. A recent briefing paper (Parliament 2021) highlights how the new ‘Freedom to speak up guardians’ exist, but in the absence of a culture to ‘speak up’ are potentially redundant.

Our findings complement arguments by Kilbourne et al (2018) who suggest more attention should be devoted to other factors in addition to staffing numbers. They suggest more resources leveraged with better measurement of patient-level health care outcomes including improved parity of esteem between mental health and general healthcare. More recently, a similar study interviewed staff working in mental health inpatient and community services and found understaffing to be self-perpetuating and cyclical, culminating in poor quality and unsafe care. These authors also describe complex and interrelating reasons for poor quality of care and urge policy makers to look beyond staffing numbers and to consider morale, burden and absenteeism also (Baker et al 2019). A report by the National Audit Office (National Audit Office 2020) states increasing nursing numbers alone has not improved matters in nursing care and a ‘long term plan’– initially outlined by the government in 2019 aims for better care and quality improvement in the next years across all health services including mental health (National Health Service 2019).

Pre-existing issues with patient outcomes will have been exacerbated by the pandemic. The State of Care report (Care Quality Commission 2020) warned against removal of legally authorised leave due to Covid19 however our findings suggest leave was already routinely restricted due to lack of resources. Turale and Nantsupawat (2021) voice their concerns following the pandemic; describing the exacerbation of clinician mental health and nursing shortages as ‘crises within crises’. In a global context including developing countries, there is a huge variation in quality of mental health care. Issues such as lack of access to basic physical health care, including disempowerment, restrictions on human rights, and patients as victims of violence (World Health Organisation 2018). As one of the wealthiest countries in the world, these issues should not be as present in UK mental health care as our finding suggest.

### *Limitations*

The variables tested in the survey were mainly job-related, ward and organisational factors. The personal and individual factors such as age, gender and level of experience were not available to us and could therefore not be included in the analysis. Similarly, we cannot be sure the qualitative data analysis is representative from across the adult nursing population. An investigation of the UK nursing population region by region would also be informative.

### *Future Direction of Research*

This study aimed to investigate RMN's self-reported reported reasons for compromised care and impact on patient outcomes. Further research could explore the phenomenon in greater depth, perhaps using semi structured interview methodology to investigate the root causes of poor quality and compromised care. As Griffiths et al (2016) argue, methodological limitations mean both overestimation and underestimation of the benefits of increased staffing are likely. We need better quality evidence to understand how resource and staffing issues impact on safety and care quality for this to be translated into policy. There is a pressing need for this research and policy change, as calls for quality improvement in acute inpatient care date back to 2016 (Royal College of Psychiatry 2016).

Much of the current evidence on understaffing and compromised care also relates to general nursing, pointing to a research gap for quality in mental health nursing. D'Lima et al (2017) argue this is exacerbated by differences of care and resource limitation between general and mental health. This paper has presented some limited evidence, but wider patient outcomes such as recovery and quality of life are missing. Further investigation of interrelating factors is required, particularly in the context of education, competency, skill mix and the increased numbers of inexperienced staff working on wards as more experienced staff leave the profession.

Our research uncovered a strong sense of mistrust amongst staff. In some instances, nurses displayed feelings of incriminated by management despite doing their best. Future work could focus on management styles in the NHS, and how the complex issue of underfunding is managed and communicated down the leadership hierarchy to staff providing care first-hand.

## *Conclusions*

A high proportion of respondents felt the care they provided on their last shift was compromised. This is due to factors relating to staffing, missed care, skill mix, higher patient acuity and issues with leadership, all acting in a cyclical and chronic manner impacting patient outcomes such as safety and recovery. From engaging with the existing body of research on staffing levels and patient outcomes, we can understand the solution is not simply to increase resources and staffing numbers to improve overall quality of care. Investigating optimal, rather than higher nurse numbers with the right skill mix and effective leadership should be prioritised by future research (Shin et al 2018).

Nurse respondents from our sample identified poor staffing as a main determinant of compromised care, however complexities were evident. Current literature on quality in mental health care is severely lacking compared with the coverage in reporting physical health research (D'Lima et al 2017). A better understanding of mental health safety and care quality should be developed, and any guidelines disseminated appropriately through NHS trusts or professional registers to frontline staff, to ensure the greatest impact.

## *Relevance for Clinical practice*

The findings of this study can also contribute to the current discussions around nurse retention. With a history of chronic underfunding and damaging attitudes towards overworking and the health of its staff, the future of patient care quality in the NHS looks bleak. Radical research and policy change is needed, to turn the tide and uncover real progress in inpatient mental health care moving forwards.

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*Table (1) Understaffing and Compromised care*

| | *Yes (n, %)* | *No (n, %)* | *Don't know* | *Total* |
|---|---|---|---|---|
| **Understaffed** | 388 (34%) | 738 (66%) | N/A | 1126 (100.0%) |
| **Was care compromised?** | 199 (47%) | 176 (42%) | 45 (11%) | 375 |

*Table (2) Nurses' self-reported reasons for compromised quality of care: Why was the quality of care compromised?*

| | *Yes (n, %)* | *No (n, %)* | *Total* |
|---|---|---|---|
| **There were not enough RN's** | 346 (30.7%) | 780 (69.3%) | 1126 (100.0%) |
| **Higher patient acuity** | 331 (29.4%) | 795 (70.6%) | 1126 (100.0%) |
| **Too much time had to be spent on non-nursing duties.** | 306 (27.2%) | 820 (72.8%) | 1126 (100.0%) |
| **Higher than expected patient demand** | 271 (24.1%) | 855 (75.9%) | 1126 (100.0%) |
| **Was there a poor skill mix(recoded)?** | 177 (15.7%) | 949 (84.3%) | 1126 (100.0%) |
| **Not enough medical staff** | 105 (9.3%) | 1021 (90.7%) | 1126 (100.0%) |
| **Not able to refer patients (outside of service)** | 92 (8.2%) | 1034 (91.8%) | 1126 (100.0%) |
| **Not able to discharge patients** | 86 (7.6%) | 1040 (92.4%) | 1126 (100.0%) |